MISSISSIPPI DEPARTMENT OF HUMAN SERVICES

DIVISION OF FAMILY AND CHILDREN'S SERVICES

CHILD AND FAMILIES SERVICE PLAN
ANNUAL PROGRESS AND SERVICES REPORT
2003

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Mississippi Department of Human Services
2003 Child and Families Service Plan
Annual Progress and Services Report

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Update:
6.6-6.8 Mississippi has established a State Level Child Fatality Review Board that has been working toward developing a statewide process for reviewing all child deaths and the ability to report on these findings on an annual basis. Through the development of this process, Mississippi is beginning to develop local expertise in the handling of child fatality cases. A District-Level Review Team Pilot has been launched in the Hinds County District and the Jefferson/Claiborne County area.

Activities:
6.6 - 6.8 Mississippi continues to maintain the State Level Child Fatality Review Team. This Child Fatality Review Team is coordinated by the Protection Unit and has been developing the process and procedures for review of child fatalities, as well as addressing issues such as needed legislation. The State Level Child Fatality Review Team has approached the Mississippi Department Health's Infant Mortality Task Force to explore the possibilities of a joining of forces to establish one comprehensive review body. Currently no resolution has been reached in that proposal. The State Level Child Fatality Review Team is responsible for the implementation of pilot review teams in local counties to evaluate effective case review methods. The Protection Unit provides staff support services to the State Level Team to fulfill its expanded role as a Citizen Review Panel to evaluate the child protection system in relation to child fatalities. This team will provide an annual report to the State Level Citizen Review Board for a comprehensive evaluation of the state child protection system each year. Training will be provided through the Protection Unit utilizing National Resource Centers or other consultants and resources available to MDHS on an on-going basis to this Team as needed to assist them in fulfilling their roles, but also to develop local expertise in handling child fatality cases.

System Outcome:

6.9 Statewide system for child abuse review

6.10 Development of local experts regarding handling of child abuse cases in relation to the judicial process

6.11 Annual report based on system review

Update:
6.9 Multi-disciplinary Child Abuse Review Teams are being expanded into each local judicial district to create a statewide system for child abuse review.

6.10 Local experts are being utilized to develop and expand child abuse review teams and, in turn, are being made available to these teams to address issues of handling these cases.

System Outcome:
2.3 Improved service provision on new cases of children in custody

Update:
2.3 The Quality Improvement instrument for case record reviews has been developed and will be implemented in the pilot counties. Region IV has a Q A Specialist. This Specialist reviews cases according to the established schedule. This benefit's caseworkers and ASWS's by identifying deficiencies that can be corrected.

Activities:
2.3 The Quality Improvement case record review instrument has been developed and will be implemented and used to review new cases quarterly to assure service provision in pilot counties.

System Outcome:
2.4/2.5 Enhanced Service Provision for children in care

Update:
2.4/2.5 Due to state and federal mandates, due to the improved policy requirements of DFCS, and due to the piloting of Quality Improvement, cases are being reviewed more than ever before. Given the continuous monitoring of cases of children from entry into custody throughout their time in foster care, service provision for children in care has been enhanced. Regional Quality Improvement Coordinators are now beginning to develop corrective action plans based on deficiencies noted in the mandated case reviews.

Activities:
2.4/2.5 Based on numerous state/federal mandates and agency policy regarding court hearings and case reviews: a) three month Administrative Review, b) six month court review, c) twelve month Permanency Hearing, d) eighteen month review; Mississippi has been working on changes to improve policy, procedures and practice to meet the many requirements for reviews in an efficient and effective manner. One major outcome of this planning includes implementing individualized service planning team meetings to be conducted at five months and 11 months prior to court hearings to prepare the workers, the families and other significant team members for the court hearing. These meetings will be used to review and update the service plans, to update the on-going assessments and to prepare the Youth Court Summary Report for the judges. With the changes discussed, the role of foster care reviewers became an issue. The foster care reviewers role will change and they will become the facilitators for these five and 11 month team meetings. The foster care reviewers will receive specialized training for social group work practice to gain the knowledge and skills necessary to facilitate such meetings and to understand their changing roles. The Youth Court Summary Report is a form that was developed by the Region I-E pilot to assure accurate reporting to the youth court judges including the mandated information for permanency hearings. This instrument is especially important given